OFFICE OF MENTAL RETARDATION SERVICES
MR WAIVER INDIVIDUAL SERVICE AUTHORIZATION REQUEST
FAX VERIFICATION FORM

Must accompany all ISARs or resubmissions submitted by CSB and will be returned to CSB upon receipt.

_____

COMMUNITY SERVICES BOARD

_____
DATE

• Fax all submissions and resubmissions to PA Specialist:	• Central Office forwards resubmissions to PA Consultant specified below**:
Vivian Stevenson **804-786-9853 PHONE** **804-786-3283 FAX** **vstevenson@dmhmrsas.state.va.us**	**Consultant:**_____ **PHONE #:**_____

CSB Contact Name: _____

_____ _____
CSB PHONE # **CSB FAX #**

	Name(s) of Individual(s) for attached ISAR(s) and Preauthorization Documentation	# Pgs. *(DON'T count this cover sheet)*	✓ if Urgent	✓** if Resub-missio n	MR OFFICE USE ONLY ISAR, etc. rec'd in C.O. (# of pgs rec'd & initials/date)		ISAR, etc. rec'd by PAC (# of pgs rec'd & initials/date)		ISAR, etc. faxed to PAS (# of pgs fx'd & initials/date)		ISAR, etc. rec'd by PAS (# of pgs rec'd & initials/date)	
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****Submitting additional information requested by the PA Consultant.**

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